Washington State Department of Social & Health Services

DIVISION OF CHILD CARE AND EARLY LEARNING (DCCEL)

HEALTH SERVICE REQUEST

FACILITY NAME	LICENSE/CONTROL NUMBER	FACILITY TELEPHONE (INCLUDE AREA CODE)

FACILITY ADDRESS	CITY	ZIP CODE	COUNTY

MAILING ADDRESS	CITY	ZIP CODE

CONTACT PERSON'S NAME AND TITLE	TELEPHONE (INCLUDE AREA CODE) EXTENSION

PREVIOUS NAME(S) OF THIS CENTER	☐ Copy of floor plan attached

PREVIOUS ADDRESS

NAME(S) OF OTHER LICENSED CENTERS PREVIOUSLY AT THIS LOCATION

DIRECTIONS TO FACILITY

CHILD CARE

☐ Child day care
☐ School age centers
☐ Family home provider
☐ Summer only
☐ Seasonal
☐ Before/after care
☐ School year only

LICENSE EXPIRATION DATE

HOURS OF OPERATION

_____ A.M. - _____ P.M.

DAYS OF OPERATION

TYPE OF HEALTH SERVICE REQUESTED

☐ Initial new ☐ Initial Relocation ☐ Initial change of owner ☐ Initial to full ☐ Renewal
☐ Complaint ☐ Increased capacity ☐ Change of environment/use (specify in comment area below)
☐ Other (follow-up, consultation) specify:

CAPACITY

CURRENT LICENSED CAPACITY	REQUESTED NUMBER OF CHILDREN	AGES	NUMBER OF INFANTS
		through years	

LICENSER'S NAME	REGION	TELEPHONE (INCLUDE AREA CODE)	DATE COMPLETED

LICENSER'S COMMENTS

HEALTH SPECIALIST'S NAME	REGION	TELEPHONE (INCLUDE AREA CODE)	DATE COMPLETED

HEALTH SPECIALIST'S COMMENTS

☐ Approved ☐ Disapproved